Dear Providers,

The following format is a sample guide for submission of a completed Behavior Analysis (BA) Assessment. Keep in mind this is only a suggested format and is not a mandatory requirement.

If you have any questions or comments please do not hesitate to contact us at Beacon Health Options.

Florida Call Center:
Phone: 866-827-7737
Fax: 855-401-6631
Hours of operation are 8AM-5PM
BEHAVIOR ANALYSIS ASSESSMENT FORMAT

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Recipient’s Name</td>
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<tr>
<td>Recipient ID</td>
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<tr>
<td>Recipient’s Age</td>
<td></td>
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<tr>
<td>Recipient’s DOB</td>
<td></td>
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<tr>
<td>Date of Report</td>
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<tr>
<td>Evaluator’s Name</td>
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Type of Assessment:
- Initial Assessment
- Reassessment

REASSESSMENT (IF APPLICABLE):
Behavior plan updates should be submitted every 6 months or at the end of the recipient’s existing authorization period.

The behavior plan update should reflect any relevant life changes (family, school, services, health, and/or medications) and the recipient’s progress in the objectives, and maladaptive behaviors identified on the initial behavior plan. Objectives should be listed in the same order as listed on the original report and include graphical progress as clinically appropriate.

In addition, new objectives, maladaptive behaviors, and/or behavior plans should be added as appropriate and indicated as such.

DOCUMENTS REVIEWED:
Documents reviewed should include the following:
- Diagnostic report
- IEP or IFSP (as applicable)
- Reports of other services provided (OT, PT, SLP, Social Skills Training, etc.)
- Psychiatric assessment (if applicable)

Please note any additional documents that are reviewed as part of the assessment.
BACKGROUND INFORMATION:
Description of background information should include a brief summary of:
- Previous treatments and results
- Current treatments and progress (please include supplements and any dietary modifications if applicable)
- Current living situation
- Relevant family history
- Medical history – particularly seizure disorder or major psychiatric disorder
  - Include current medications
    - Are psychotropic medications being prescribed?
      - Name of medication
      - Prescribing Doctor
- Education status
  - Where does the recipient attend school?
  - Specialized classroom?
  - Require an aide?
  - Treatments received within school?

OBSERVATIONS:
Include dates of observations and description. Assessment should include at least two direct observations of the recipient.

STRENGTHS AND WEAKNESSES:
Include a description of the recipient’s strengths and weaknesses. Strengths and weaknesses may be determined through assessments such as the CARS, Vineland or VB-MAPP.

MALADAPTIVE BEHAVIORS:
Identify maladaptive behaviors. These are behaviors that are identified for reduction. When stating behavior objectives include current topography (what the behavior looks like), intensity, and frequency. Note progress made on behavior objectives from last progress report. Please include baseline levels for all maladaptive behaviors.

ASSESSMENTS CONDUCTED:
Identify any assessments conducted and a summary of the results. Possible assessments include; FAST, MAS, QABF, A-DOS, ABLLS, VB-MAPP, Functional Assessment Interview, Functional Analysis, etc.
The clinician is free to determine the most appropriate assessment to evaluate the recipient. However, if a maladaptive behavior has been identified, an assessment should be conducted to determine the function of the behavior.

DATA COLLECTED:
In the case of a reassessment, present summary of data collected for each objective and maladaptive behavior. Please be sure to note treatment objectives that have been achieved or show significant improvement. Also note objectives that show a lack of progress and related treatment revisions.

Objectives should be listed in the same order as listed on the original report and include graphical progress as clinically appropriate.

FAMILY/CAREGIVER INVOLVEMENT:
The parent / guardian / caregiver must participate to the fullest extent possible in BA services provided to recipients. Include a description of caregiver involvement and caregiver/family identified for training. Also document if the caregiver/family is not able to participate in training and why. Supporting documentation of the parent’s/guardian’s/caregiver’s inability to participate in BA services must accompany the request for continued stay.

List specific goals identified for caregiver/family training and note progress from last reporting period. Please include baseline levels for all caregiver training objectives.

Document any assistance provided to caregivers or others to carry out the approved behavior support/maintenance plans.

GENERALIZATION TRAINING:
Include description of training plan for generalizing skills into all areas of recipient’s environment.

GOALS:
Identify goals directly related to recipient’s maladaptive behaviors.

Objectives should relate to the recipient’s maladaptive behaviors and should be derived from the functional assessment and/or evidence-based assessments that occur prior to initiating treatment.

Objectives should be measurable, observable, age appropriate and achievable. The statement of the objectives should include the baseline measurement, current level of performance, and the anticipated level of achievement of the recipient at the end of the authorization period.
Objectives should neither be educational in nature nor overlap IEP objectives. Provide justification if objectives are included in the plan which would fit into the above mentioned categories.

**BEHAVIOR PLAN COMPONENTS:**

Maladaptive behaviors must be identified.

Both preventative and reactive strategies should be included in addressing maladaptive behaviors. Note any functional replacement skills identified.

**PREFERENCE ASSESSMENT:**

A preference assessment is recommended in order to determine appropriate reinforcers to be incorporated into recipient’s treatment.

Specify reinforcers and potential reinforcers identified for use.

For a reassessment, note any changes to previously identified reinforcers, (i.e., fading from food rewards to tokens system).

**RISK ASSESSMENT:**

The risk assessment should include a description of the risks associated with engaging in treatment as well as refusing to engage in the behavior plan.

**TRANSITION PLAN (IF APPLICABLE):**

Transition plans may include several components depending on the recipient’s situation. A transition plan should be created when:

a. The recipient is preparing to transition to a less restrictive environment placement.

b. The recipient is preparing to transition from a home-based BA services to a school-based services.

c. A transition plan should also address how the recipient will transition into adulthood. For example, will the focus be on academic skills or life skills.

**DISCHARGE CRITERIA:**

Discharge criteria must include requirements for discharge, discharge date, next level of care, clinical evaluation of parent/guardian or caregiver’s capacity to continue behavior interventions without practitioner’s guidance and linkages with other services.
CRISIS PLAN:

If the recipient does not display maladaptive behaviors that are a risk for harm to self or others this should be noted and the section labeled N/A.

Please check risk factors as applicable.

- Assaultive behavior
- Self-Injurious Behavior (SIB)
- Elopement
- Sexually offending behavior
- Fire setting
- Current substance abuse
- Impulsive Behavior
- Psychotic symptoms
- Self-mutilation/cutting
- Caring for ill family recipient
- Current family violence (abuse, violence)
- Coping with significant loss (job, relationship, financial)
- Prior psychiatric inpatient admission
- Other ________________________________

Suicidality:
- Not Present
- Ideation
- Plan
- Means
- Prior attempt (last 12 months)

Homicidality:
- Not Present
- Ideation
- Plan
- Means
- Prior attempt (last 12 months)

A crisis plan includes active steps or self-help methods to encourage de-escalate or defuse crisis situations, names and phone numbers of contacts that can assist in the prevention or de-escalation of behaviors. Please note specific instructions on what parents/guardians/caregivers should do after hours. (i.e., Call 9-1-1 in case of an emergency situation.)
**COMMUNICATION WITH OTHER PROVIDERS:**

Please check boxes as applicable.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A, Provider is the Prescriber</th>
<th>N/A, Recipient is not on medication</th>
<th>Recipient Declined</th>
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<tbody>
<tr>
<td>Have you communicated with the recipient’s prescriber of psychotropic drugs?</td>
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<td>Have you communicated with the recipient’s PCP?</td>
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<td>Have you documented the communication or recipient declination?</td>
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<tr>
<td>Have you been in communication with other Behavior Health (BH) providers for this recipient?</td>
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<td>If yes, please indicate the type of BH provider.</td>
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</table>
**SUMMARY AND RECOMMENDATIONS:**

A summary of the assessment should be included with justification for treatment recommendations.

Include a breakdown of number of hours requested for services by procedure code.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description of Service</th>
<th># of Units / Quarter Hours Requested</th>
<th>Breakdown per Week</th>
<th>Location (Where Services are to be Delivered)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: H2019</td>
<td>Behavior Analysis  -Lead Analyst</td>
<td>104 units</td>
<td>1 hour per week</td>
<td>In home</td>
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<tr>
<td>Example: H2019</td>
<td>Behavior Analysis  -Lead Analyst Parent Training</td>
<td>52 units</td>
<td>0.5 hours per week</td>
<td>In home</td>
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Lead Analyst Signature:

________________________  ____________________
Signature                  Date

Parent/Guardian/Caregiver Signature:

________________________  ____________________
Signature                  Date